Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WOL+MED
EDWARD WOLSKI MD
2436 I35 EAST SOUTH STE 336
DENTON TX 76205

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box
Box Number 44

MFDR Tracking Number
M4-05-6826-01

MFDR Date Received
JUNE 18, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied payment using PEC-F on 11/20/3. There is a MAR assigned to this service but the carrier failed to pay this amount. We charged for 4 units of the service but the carrier seems to have only reimbursed for two. But using PEC-F the carrier is stating that they are referencing the fee guidelines to make this reduction. Because they failed to pay according to the fee guidelines, it is inappropriate to use PEC-F. The carrier has used the incorrect PEC… Additionally the carrier has failed to respond to our request for reconsideration. This is a violation of Rule 133.304… For dates of service 9/9/3, 9/13/3, 9/18/3, 10/2/3, 1/12/4, 1/20/4 and 1/21/4 the carrier failed to respond to our initial billing and our request for reconsideration. We feel they have failed to comply with Rule 133.304, Medical Payments and Denials… We also fee the carrier has failed to comply with Rule 134.304(I) by not responding to our request for reconsideration… We feel we should be reimbursed with interest."

Amount in Dispute: $2,872.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent's agent, Broadspire, did not submit a position summary with their response to the request for medical fee dispute resolution.

Response Submitted by: Broadspire, PO Box 701809, Dallas, TX 75370

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2003, September 13, 2003, September 18, 2003, September 25, 2003 October 2, 2003, November 20, 2003, January 12, 2004	CPT Codes 97110 (10 Units total) CPT Code 97113 (8 Units total) CPT 97530 (10 Units total) CPT Code 99070 (1 Unit) CPT Code 97999 (1 Unit) CPT Code 20550 (4 Units) CPT Code 97545-WH-CA (3 Units) CPT Code 97546-WH-CA (20 Units)	$2,872.69	$2,522.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. 28 Texas Administrative Code §134.202 sets out guidelines for reimbursement of health care.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 23, 2003:
   - F – Fee Guideline MAR reduction

Findings

1. The requestor billed one unit of CPT Code 99070, Aquatics and one unit of CPT Code 97999, Aqua Jet). These codes are not priced by the Division or Centers for Medicare and therefore fall under the provision of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(g)(3)(D), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated. As a result, the amount ordered is $0.00
2. In accordance with 28 Texas Administrative Code §134.202(b) and(c)(1) and (6) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. (c)To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1)for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (6)for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments.

   The requestor billed eight (8) units of CPT Code 97113 - aquatic therapy with therapeutic exercises. According to 28 Texas Administrative Code §134.202, CCI edits were run and procedure code 97530 and component procedure 97113 are unbundled. As a result, the amount ordered for CPT Code 97113 is $0.00

   The requestor billed four (4) Units of CPT Code 20550 - Injection(s); single tendon sheath, or ligament. Review of the EOB submitted by the respondent shows reimbursement in the amount of $33.35 per unit was paid for a total of $133.40. Review of the submitted documentation supports reimbursement in accordance with 28 Texas Administrative Code §134.202. Reimbursement for each unit is priced $66.70; as a result, the amount ordered is $133.40.

   The requestor billed a total of four (4) units of CPT Code 97012 - Application of a modality to 1 or more areas; traction, mechanical. In accordance with 28 Texas Administrative Code §134.202 each unit is priced at $17.21. Review of submitted documentation supports reimbursement. As a result, the amount ordered is $68.84.

   The requestor billed a total of twenty (10) units of CPT Code 97110 - Therapeutic procedure, 1 or more areas, each

15 minutes. In accordance with 28 Texas Administrative Code §134.202 each unit is priced at $32.64. Review of submitted documentation supports reimbursement. As a result, the amount ordered is $326.40.

The requestor billed a total of twenty (10) units of CPT Code 97530 - Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes. In accordance with 28 Texas Administrative Code §134.202 each unit is priced at $32.96. Review of submitted documentation supports reimbursement. As a result, the amount ordered is $329.60.

3. In accordance with 28 Texas Administrative Code 134.202(e)(5)(A)(i) and (C)(i-ii), The following shall be applied for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a commission Return to Work Rehabilitation Program, a program should meet the "Specific Program Standards" for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual. Section 1 standards regarding Organizational Leadership, Management and Quality apply only to CARF accredited programs. Accreditation by the CARF is recommended, but not required. If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100% of the MAR. Work Hardening/Comprehensive Occupational Rehabilitation Programs (for commission purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.) The first two hours of each session shall be billed and reimbursed as one unit, using the "Work hardening/conditioning; initial 2 hours" CPT code with modifier "WH." Each additional hour shall be billed using the "Work hardening/conditioning; each additional hour" CPT code with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier. Reimbursement shall be $64.00 per hour. Units of less than 1 hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

   The requestor billed three (3) hours of CPT Code 97545-WH-CA; review of the work hardening notes support reimbursement. As a result, the amount ordered is $384.00.

   The requestor billed twenty (20) hours of CPT Code 97546-WH-CA; review of the work hardening notes support reimbursement. As a result, the amount ordered is $1,280.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,522.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,522.24 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 8, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.